Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Enrollment and Change Form

Administrative Offices: Downers Grove, Illinois I Dallas, Texas

☐ New Enrollment ☐ Change ☐ Open Enrollment ☐ COBRA ☐ Retiree

Employer/Employee Section

Enrollment forms must be submitted directly to Dearborn National unless the group is self-administered. If the group is self-administered, submit enrollment forms to Dearborn National only if evidence of insurability is required.

EMPLOYER County of El Paso		GROUP NO. / ACCOUNT NUMBER F019471		LOCATION	
EMPLOYEE NAME - LAST	FIRST	MIDDLE INITIAL	GENDER ☐ M ☐ F	DATE OF BIRTH	DATE OF HIRE (FULL TIME)
SOCIAL SECURITY NO.	EARNINGS Hourly ☐ Weekly ☐ Monthly ☐ Annual ☐			JOB TITLE	CLASS
HOME ADDRESS		CITY	STATE	ZIP	
HOME PHONE	WORK PHONE		CELL PHONE		

BENEFIT SELECTION - Life

COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. **Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.**

Basic Coverage (check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.			
☒ Term Life / AD&D			
Supplemental Coverage (check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.	(A)Add, (C)Change (D)Delete	Total Amount of Coverage Desired	If (C)hange, list Prior Coverage
☐ Term Life Employee			
☐ Term Life Spouse			
☐ Term Life Child(ren)			

SPOUSE NAME (if Applicant)	- LAST	FIRST	M.I.	SEX ☐ M ☐ F	SPOUSE DATE OF BIRTH	SPOUSE SOCIAL SECURITY #

BENEFICIARY DESIGNATION: (For Employee Only: Must Be Completed if you have applied for Life or AD&D insurance.) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

First Name Last Name	Social Security No.	Date of Birth	Relationship	Percentage
Primary				%
Primary				%
Contingent				%
Contingent				%

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy (ies) issued to the employer listed above. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I do not remain actively at work that my coverage may lapse or terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

FOR DEARBORN NATIONAL USE ONLY

EMPLOYEE SIGNATURE _____ DATE / /

Waiver of Coverage:

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

EMPLOYEE SIGNATURE _____ DATE / /